STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #29469 were completed on July 31, 2012 through August 2, 2012 Deficiencies were cited related to complaint investigaion #29469 under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications), a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	F157 It is the practice of this facility to ensure that the resident, physician and/or legal representative is consulted when …a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);. 1) Resident #24's attending physician was notified on June 6, 2012 of the Geropsych Consultant recommendation to decrease the dosage of seroquel and disagreed with the recommendation. The DNS/ADNS or designee will review all residents on Geropsych services in the past 60 days from survey end date 08/02/2012, recommendations and review the medical records for confirmation of physician notification. This review will be completed by 8-31-2012 2) The DNS/ADNS/Unit Manager or designee will review all Consultant recommendations on the day the recommendations are written and notify the attending physician by telephone, or by facsimile within 1 work day.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
B. Stitt	Ex Director	8/17/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician of a psychiatric recommendation for one (#24) of forty residents reviewed in Stage Two The findings included. Resident #24 was admitted to the facility on August 28, 2009, with diagnoses including Dementia with Behavior, Failure to Thrive-Adult, and Hypertension. Medical record review of a Psychiatric Note dated May 29, 2012, revealed ".. evaluate and provide med (medication) management of psychoactive medications used to treat dementia with delusions...staff report resident has been isolating self and feels...sleeping too much...Recommend to Primary Care Physician the following. Reduce Seroquel to 25 mg (milligrams) (at) HS (bedtime)..." Interview on August 2, 2012, at 10:15 a.m., with the Director of Nursing, in the conference room, confirmed the facility had failed to notify the physician of the psychiatric recommendation dated May 29, 2012	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 3)Licensed Nursing personnel will be educated on the requirement of timely notification to the attending physician on all Consultant recommendations. This education will be done by the Staff Development Coordinator (SDC), or the Director of Nursing Services (DNS) or designee on August 23, 24, 28 ,29 and 30. Each weekday during clinical rounds, resident change of condition/recommendations by consultant will be reviewed by the DNS/ADNS, SDC, Case Management Coordinator (CMC), Minimum Data Set (MDS) Coordinator. Audits on resident change of condition/recommendations by consultants will be reviewed for MD/family notification. These audits are submitted to the DNS/designee for review and follow up. The DNS/designee will ensure that follow up is completed for all changes of condition/recommendations by consultant through review of audits and resident medical records review. The results of these audits will be presented to the Quality Assurance Committee (Administrator, DNS, ADNS, SDC, Social Services, RD, Maintenance, Activities, and Medical Director) monthly for review and action as indicated.	08/31/2012
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by. Based on medical record review, observation, and interview, the facility failed to promote care that maintained or enhanced dignity for one (#2) of two sampled residents of the forty residents reviewed in Stage Two. The findings included Resident #2 was admitted to the facility on March 5, 2009, and readmitted to the facility on March 9, 2011, with diagnoses including Cerebral Vascular Accident, Hypertension, Convulsions and Acute Respiratory Failure Medical record review of the quarterly Minimum Data Set (MDS) dated April 16, 2012, revealed the resident had short and long term memory problems, makes self understood, totally dependent for all activities of daily living (ADL'S), and had a gastrostomy tube Medical record review of the Care Plan dated July 20, 2012, revealed "...prior to initiating physical care use gentle tones and explain task to be done..." Observation on July 31, 2012, at 12:22 p m , in the resident's room, revealed the resident lying on the bed with the privacy curtain not pulled, and the door to the hallway open Continued observation revealed Licensed Practical Nurse (LPN) #3 entered the room (without closing the	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F241 It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The DNS/ADNS/SDCC and/or designees will in-service all nursing personnel on August 23,24,28,29 and 30 on resident rights with an emphasis on addressing residents in a respectful manner, identifying themselves upon entering a room and declare to the resident what care they are about to perform. The DNS/ADNS/SDC and/or designees will conduct resident observation and resident interviews on 10% of the residents on each unit monthly X three months, then quarterly X 2 quarters, then an aggregate of 30% of in-house census in facility every 6 months to ensure and receive feedback from residents they are being treated with respect and dignity. The DNS/ADNS/SDC or designee will report results of these interviews and observations to the Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Maintenance, Activities, and Medical Director) for review and discussion with recommendations, as indicated.	7-31/8-1-2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3 door) did not address the resident, removed the covers from the resident, pulled the gastrostomy tube attached to the resident to verify the gastrostomy tube was attached to the feeding pump, and placed the covers back on the resident and left the room without explaining care/task. Interview with LPN #3 on July 31, 2012, at 12.25 p m., on the E-Hall, confirmed not closing the door to hallway, not explaining the care/task, and not pulling the curtain during care/task did not maintain the resident's dignity and respect the resident's individuality	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility, and make choices about aspects of his or her life in the facility that are significant to the resident This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to allow one (#165) to make choices of four residents sampled of forty residents reviewed in Stage Two The findings included: Resident #165 was admitted to the facility on March 2, 2011, and readmitted on February 7, 2012, with diagnoses including Hypertension.	F 242	F242 It is the practice of this facility to allow residents the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Resident #165's preference (choice) of shower/bathing time has been established and communicated to the nursing staff through care plan and C.N.A. assignment sheets. DNS/ADNS, Unit Managers and/or designee will interview residents on each unit on satisfaction with current bath/shower schedule and make any requested adjustments, communicate any adjustments to nursing staff, update Care Plans and C.N.A. assignment sheets by August 31, 2012.	08/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 242 Continued From page 4

Burkitts Lymphoma, and Polyarthritis.

Medical record review of an admission Minimum Data Set (MDS) dated February 13, 2012, revealed ". .very important to choose between a shower and a bed bath..."

Medical record review of a quarterly MDS dated May 9, 2012, revealed ". the resident was cognitively intact for daily decision making..."

Medical record review of a Care Plan dated May 22, 2012, revealed " . self care deficit...bathing/shower/hygiene...shower/bath ..2 times a week "

Medical record review of PRN (as needed) Nurse Aid Notes dated June 13, 2012, revealed " ..resident rec (received) shower at 3 a.m. due to quall (Kwell) treatment. ."

Medical record review of a PRN Nurse Aid Notes dated June 19, 2012, revealed "...res (resident) rec shower at 2:30 a.m. due to quall (Kwell) treatment.."

Medical record review of a PRN Nurse Aid Notes dated July 5, 2012, revealed " resident received complete bed bath due to not having a lift sling. "

Interview with the resident on July 31, 2012, at 3.45 p m , in the resident's room, revealed the resident did not like having received a shower at 2:30 a.m., and 3 a.m. Contunued interview revealed the resident would like to shower daily after breakfast and had not been given the choice

F 242

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

The DNS/ADNS/SDCC and/or designees will in-service all nursing personnel on August 23,24,28,29 and 30 on resident choices to include but not limited to type of and times for baths.

The DNS/ADNS/SDC and/or designees will conduct resident observation and resident interviews on 10% of the residents on each unit monthly X three months, then quarterly X 2 quarters, then an aggregate of 30% of in-house census in facility every 6 months to ensure and receive feedback from residents related to bathing and bath times.

The DNS/ADNS/SDC or designee will report results of these interviews and observations to the Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Maintenance, Activities, and Medical Director) for review and discussion with recommendations, as indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 5 Interview with the Director of Nursing (DON) on August 2, 2012, at 10:30 a.m., in the DON office, confirmed the facility failed to allow one resident a choice of when to get a shower.	F 242	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following. Identification and demographic information; Customary routine, Cognitive patterns; Communication, Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions, Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures, Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F272 It is the practice of this facility to use the results of the Minimum Data Set (MDS) Assessment to develop, review and revise the resident's comprehensive plan of care. This facility develops comprehensive care plans for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 1) The appropriate diagnosis was added to the MDS of Resident # 39 on 8/3/12 and the corrected MDS was transmitted. 2The Minimum Data Set Nurses (MDS Nurse) will review the most current Minimum Data Set (MDS) for each resident identified through the Resident Reporter in the Resident Care System to assess the accuracy of diagnoses for residents with broken or loosely fitting dentures, cavity or broken natural teeth, pain, discomfort, difficulty chewing. The MDS Nurses will correct any information deemed to be inaccurate prior to transmission of the MDS by 9/10/12.	09/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 6	F 272	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

This REQUIREMENT is not met as evidenced by.
Based on medical record review, observation, and interview, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for one (#39) of thirty-one sampled residents of the forty residents who were reviewed in Stage Two.

The findings included:

Resident #39 was admitted to the facility on May 31, 2004 and readmitted on November 1, 2010, with diagnoses including Insulin Dependent Diabetes, Vascular Dementia, and Osteoporosis

Medical record review of the quarterly MDS dated July 16, 2012, revealed no chewing problems

Medical record review of the nutrition note dated July 19, 2012, revealed "...weight has steady decline, weight in range, mechanical soft diet due to chewing problems "

Observation on July 31, 2012, at 10:26 a.m., in the resident's room, revealed the resident only used the upper denture.

Interview with the resident on July 31, 2012, at 10:26 a.m., in the resident's room, confirmed the resident had a chewing problem and was unable to wear the lower denture.

The MDS Nurses will verify the accuracy of the coded information on each MDS prior to affixing their signatures and again before transmission

The Clinical Case Manager(CM)/MDS Coordinator(MDSC) or designee will monitor through random record review for accuracy of the MDS at least 10% of records each month X 3 months and then at least quarterly thereafter.

The data will be reviewed, analyzed and reported to the Facility Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Maintenance, Activities, and Medical Director) by the CM/MDSC for any subsequent plan of action that may be deemed necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 272 Continued From page 7

Interview with Licensed Practical Nurse (LPN) #1 on August 2, 2012, at 10:06 a.m., in the MDS office, confirmed resident #39 had a chewing problem and the MDS was not accurate.

F 279 SS=E 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4)

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to develop a comprehensive care plan for five (#39, #174, #89, #102, and #170) of thirty -one sampled residents of forty residents reviewed in Stage Two

F 272 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F279

08/31/12

It is the practice of this facility to use the results of the Minimum Data Set (MDS) assessment to develop, review and revise the resident's comprehensive plan of care.

Resident # 39's care plan has been corrected to include chewing problems on 8/3/12
Resident # 174's care plan has been corrected to include addressing dental issues on 8/2/12
Resident # 89's care plan has been corrected to include discharge plans on 8/3/12
Resident # 102's care plan has been corrected to include indwelling foley catheter care on 8/3/12
Resident # 170's care plan has been corrected to included impaired vision on 8/3/12

The MDS Coordinators/MDS Nurses and/or Unit Managers through MDS review, physician order review, patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8	F 279	*This Plan of Correction is the center's credible allegation of compliance.*	

The findings included:

Resident #39 was admitted to the facility on May 31, 2004, and readmitted on November 1, 2010, with diagnoses including Insulin Dependent Diabetes, Vascular Dementia, and Osteoporosis.

Medical record review of the Care Plan dated July 20, 2012, revealed no care plan for chewing problem.

Medical record review of the nutrition note dated July 19, 2012, revealed "...weight has steady decline, weight in range, mechanical soft diet due to chewing problems .."

Observation on July 31, 2012, at 10:26 a.m., in the resident's room, revealed the resident only used the upper denture.

Interview with the resident on July 31, 2012, at 10.26 a.m., in the resident's room, confirmed the resident had a chewing problem and was unable to wear the lower denture.

Interview with Licensed Practical Nurse (LPN) #1 on August 2, 2012, at 10:06 a.m., in the MDS office, confirmed resident #39 had a chewing problem and confirmed the facility failed to develop a comprehensive care plan for a chewing problem

Resident #174 was admitted to the facility on December 8, 2010, with diagnoses including Urinary Tract Infection, Falls, Weakness, and Hypotension.

Medical record review of the quarterly MDS dated

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

nursing evaluation review and/ or resident interview & observation will either verify/identify residents with chewing problems, dental issues, impaired vision, foley catheters and /or expressed a desire to return to community and audit applicable care plans for appropriate problem/goal/interventions by 8/31/2012.

The DNS/ADNS/SDCC and/or designees will in-service all licensed nursing staff on August 23,24,28,29 and 30 on developing, reviewing and/or revising the comprehensive care plan to reflect residents current status. Members of the Interdisciplinary Care Team (IDT – nursing, social, dietary, activities) will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9	F 279	*This Plan of Correction is the center's credible allegation of compliance.*	

June 6, 2012, revealed no dental problems

Medical record review of the care plan dated June 22, 2012, revealed no dental problem had been identified.

Medical record review of the Dental Progress Note dated July 18, 2012, revealed ". .impressions: upper plate partial...lower plate partial...tissue condition: inflammation soft debris periodontal involvement...perfect candidate for partials.. "

Observation on July 31, 2012, at 10:12 a.m , in the resident's room, revealed resident #174 had no teeth in the front and teeth fragments on both sides.

Interview with the resident on July 31, 2012, at 10:12 a.m., in the resident's room, confirmed the dentist had made impressions and the resident was getting partials.

Interview with LPN #1 on August 1, 2012, at 3:30 p.m., in the MDS office, confirmed resident #174 had been fitted for partials, and confirmed the facility failed to develop a comprehensive care plan for the dental problem.

Resident #89 was admitted to the facility on April 12, 2012, with diagnoses including Diabetes, Anemia, Atrial Fibrillation, Hypertension, Left Below the Knee Amputation, and Bilateral Lower Extremity Deep Venous Thrombosis.

Medical record review of the Resident Progress Notes dated April 18, 2012, revealed ".. has no current d/c (discharge) plan but hopes to go

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

review each care plan, (due for that particular assessment period), at each care plan meeting, which are scheduled weekly to ensure accuracy.
The IDT will conduct weekly audit X 4 weeks, monthly audit X 2 months and then quarterly audits of comprehensive care plans to ensure it accurately reflects the individual resident's current status, needs, expectations and goals with the appropriate interventions.

3) MDS Coordinator(s) will present results of the audits to the Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Maintenance, Activities and Medical Director) monthly for review and action, as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10	F 279	*This Plan of Correction is the center's credible allegation of compliance.*	

home in the future ."

Medical record review of the Care Plan reviewed on July 26, 2012, revealed no interventions to address the resident's discharge needs, or desire to return home.

Observation on August 2, 2012, at 9:55 a.m., revealed the resident lying on the bed, coughing, and complaining of bronchial trouble. Interview with the resident, at this time, revealed the resident would like to go home, but had no plans to go home at the present time.

Interview on August 2, 2012, at 10:35 a.m., with Licensed Practical Nurse #1, in the Minimum Data Set office, confirmed the Care Plan reviewed on July 26, 2012, did not address the resident's desire to return home or interventions to address discharge planning.

Resident #102 was admitted to the facility on April 17, 2012, with diagnoses including Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Peripheral Arterial Disease, Congestive Heart Failure, History of Depresssion and Bipolar Disorder

Medical record review of the July and August 2012, physician's recapitulation orders revealed "...Indwelling catheter: (urinary) Cath (catheter) #18 FR (french) with 10ml (milliliter) balloon to BSD (bedside drainage). Change monthly on the 17th et (and) prn (as needed) and document in med (medical) record...rationale for use: Strict I & O (intake and output). "

Medical record review of the Care Plan reviewed

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

Corrective actions documented on pages 8-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 279 Continued From page 11

on July 26, 2012, revealed no interventions to address the care of the urinary catheter

Observation on August 1, 2012, at 3:35 p.m., revealed the resident seated in a wheelchair, in the resident's room, with a urinary drainage bag located in a privacy bag attached to the back of the resident's wheelchair.

Interview on August 2, 2012, at 8:30 a.m., with Licensed Practical Nurse #1, at the nursing station, confirmed the Care Plan did not address the care of the urinary catheter.

Resident #170 was admitted to the facility on February 3, 2011, with diagnoses including Congestive Heart Failure and Pneumonia.

Medical record review of the Minimum Data Sets dated April 16, 2012, and July 11, 2012, revealed the resident had impaired vision and could see large print, but not regular print in newspapers and books.

Medical record review of the Care Plan reviewed on July 19, 2012, revealed "...Blindness in left eye..." Continued review of the Care Plan revealed no interventions to address the resident's impaired vision.

Observation and interview with the resident on August 2, 2012, at 12:20 p.m., revealed the resident lying on the bed watching television. Interview with the resident, at this time, revealed the resident had glasses from the drug store, was unable to see out of the left eye, the resident's eye sight was getting worse and the resident needed an eye examination.

F 279

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

Corrective actions documented on pages 8-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 12 Interview on August 2, 2012, at 12:55 p.m., with the Director of Nursing (DON), in the DON's office confirmed the resident's Care Plan did not address interventions related to the resident's impaired vision	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by Based on medical record review and interview, the facility failed to complete an interim care plan to address falls for one (#230) of thirty-one sampled residents of the forty residents reviewed in Stage Two The findings included: Resident #230 was admitted to the facility on July 18, 2012, after hospitalization following a fall. Medical record review of the Interim Care Plan (no date) revealed the Interim Care Plan did not address the resident's fall risk. Interview with the Director of Nursing (DON), in the DON office, on August 1, 2012, at 2:54 P.M., confirmed the Interim Care Plan did not address the resident as a fall risk.	F 281	F281 It is the practice of this facility that the services provided or arranged by the facility will meet professional standards of quality. -Resident #230 has been placed on the facility fall prevention program, to include bed in safest low position, clip alarm, falling star icon on nurse call system and resident room doorframe. Comprehensive care plan is in place and dated on 08/01/2012 -All admissions within 21 days of survey without a comprehensive care plan were audited to ensure interim care plan addressed admission risk assessments including high risk for falls on _08/31/12_____. -All new admissions will be reviewed by the Clinical Rounds Team (DNS,ADNS,SDC, CM,MDS Coor, Unit Managers) weekday mornings and validate that an interim care plan has been developed with appropriate interventions, approaches and timeframes based on nursing admission assessment, including a residents assessed at high risk for falls ,. -Licensed nursing staff will be in-serviced by the Director of Nursing or designee on the development of the interim care plan to include problems, goals, dates and appropriate interventions for new admissions based on the nursing admission assessment, including but not limited to the risk assessments, physician orders and medical diagnosis.. -The DNS/ADNS/SDC and/or designees will conduct an audit at least 25% of new admissions weekly X 4 weeks, then 10% new admissions X 2 months and the 5% per quarter X 3 quarters. -The DNS/ADNS/SDC or designee will report results of the audits to theFacility Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Maintenance, Activities, and Medical Director)monthly meeting for review and discussion with recommendations, as indicated.	08/31/12
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 282 Continued From page 13

must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to implement the Care Plan for one (#2) of thirty-one sampled residents of forty residents reviewed in Stage Two.

The findings included:

Resident #2 was admitted to the facility on March 5, 2009, and readmitted to the facility on March 9, 2011, with diagnoses including Cerebral Vascular Accident, Hypertension, Convulsions and Acute Respiratory Failure

Medical record review of the quarterly Minimum Data Set (MDS) dated April 16, 2012, revealed the resident had short and long term memory problems, makes self understood, totally dependent for all activities of daily living (ADL'S), and had a gastrostomy tube.

Medical record review of the care plan dated July 20, 2012, revealed " ..keep adapted call light in proper position for use "

Medical record review of a Nurse's Progress note dated July 20, 2012, revealed " .call bell in place. "

Observation on August 1, 2012, at 2 30 p.m., in the resident's room revealed a push button call

F 282 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F282

08/31/12

It is the practice of this facility to provide and/or arrange for services to be provided by a qualified person in accordance with each resident's written plan of care.

Resident # 2's adaptive call light is in proper position for use as per the care plan on 8/2/12.

There are three additional residents who require the use of an adaptive call light, These adaptive call lights are in place for the resident's easy access and use, these devices are noted on the residents individual care plan and on the C.N.A. assignment sheets.
Licensed nursing staff will be in-serviced on requirement to assess all new admissions and re-assess at least quarterly on ability to use a standard call light or for the need of an adaptive call light on August 23,24,28,29 and 30, 2012.
Unit Managers will maintain a list of residents with an adaptive call light at each nurse station and monitor for presence and proper placement during routine rounds.
The facility will stock 2-3 extra adaptive call lights in central supply.
The DNS/ADNS or designee will monitor presence and placement of adaptive call lights 2-3 times a week during Clinical Rounds to ensure on-going compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 14 light attached to the raised side rail on the right side of the rail Interview with Registered Nurse (RN) #1 on August 1, 2012, at 2.33 p m., in the station three nurse's station, revealed the resident had been unable to use a button call light, had been able to use an adaptive touch call light with the head and confirmed the resident did not have an adaptive touch call light in position for use	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 312 SS=D	483 25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene This REQUIREMENT is not met as evidenced by Based on medical record review, observation, and interview, the facility failed to provide incontinence care for one (#53) of five sampled residents of forty residents reviewed in Stage Two The findings included. Resident #53 was admitted to the facility on March 11, 2009, and readmitted on October 27, 2011, with diagnoses of Congestive Heart Failure, Emphysema, and Chronic Obstructive Pulmonary Disease. Medical record review of the quarterly Minimum Data Set (MDS) dated July 11, 2012, revealed the	F 312	F312 It is the practice of this facility to provide care to any resident who is unable to carry out activities of daily living and will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. C.N.A. #1 identified as assigned to resident #53 was in-serviced on providing timely incontinent care and turning/repositioning every two hours as care planned or as needed, and to document on flow sheet ant residents refusal and to notify charge nurse on 7/31/12. All residents identified as incontinent will have be checked every two hours and incontinent care provided as necessary, The resident care plans and C.N.A. assignment sheets have been reviewed and updated as necessary. All nursing staff will be in-serviced on August 23,24,28,29 and 30, 2012 on the importance of checking and providing incontinence care at least every two hours, documenting resident refusal and notifying charge nurse of such for appropriate follow-up. The Staff Development Coordinator or designee will include a review of this policy/procedure in orientation of nursing staff. The Unit Managers will monitor during daily rounds to ensure incontinent care is performed as care planned, ordered and as needed.	08/31/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 15 resident was cognitively intact, totally dependent for all activities of daily living (ADL'S), and was incontinent of bladder Medical record review of the care plan dated July 20, 2012, revealed "...incontinence of B/B (bowel and bladder) ..check Q (every) 2 hrs (hours). " Observation on July 31, 2012, at 12 40 p.m., in the resident's room, revealed the resident sitting in a wheelchair. Interview with resident #53 on July 31, 2012, at 12.40 p.m , in the resident's room, revealed the resident had not been changed since this morning before breakfast, had been incontinent of urine, and was uncomfortable in wet clothes. Interview with Certified Nurse Aide (CNA) #1 on July 31, 2012, at 12:40 p.m., in the 200 hallway, confirmed the resident was incontinent of bladder, was to be checked for incontinent episodes every two hours, with pericare to be provided, and confirmed the resident had not been checked since 7 30 a.m Interview with CNA #1 on July 31, 2012, at 1:00 p m , in the 200 hallway, confirmed the resident had been changed at 12:45 p.m , had been incontinent of bladder, and it had been five hours since the resident had been checked for incontinence. C/O #29469	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Director of Nursing, Unit Manager or designee(s) will audit delivery of incontinent care through observation rounds at least 2 times a week on all units and all shifts care and turning/repositioning as indicated. The Director of Nursing or designee will monitor through direct observation and record review of nursing staff performing personnel hygiene, special attention to turning / repositioning and incontinent care every two hours as delineated in the resident care plan or as needed. This data will be reviewed and analyzed at the Quality Assurance Committee meeting monthly for the next three months and then quarterly thereafter with subsequent Plan of Action developed and implemented as indicated.	
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment	F 313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 313 Continued From page 16

and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to obtain vision services for one (#170) three sampled residents of forty residents reviewed in Stage Two.

The findings included:

Resident #170 was admitted to the facility on February 3, 2011, with diagnoses including Congestive Heart Failure and Pneumonia

Medical record review of the annual Minimum Data Set (MDS) dated January 18, 2012, revealed ". .vision adequate sees fine detail, including regular print in newspapers/books.. "

Medical record review of the quarterly MDS dated April 16, 2012, and July 11, 2012, revealed the resident had impaired vision and could see large print, but not regular print in newspapers and books.

Observation and interview with the resident on August 2, 2012, at 12:20 p.m., revealed the resident lying on the bed watching television. Interview with the resident, at this time, revealed

F 313

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F313
It is the practice of this facility to ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, including making appointment and arranging for transportation to and from the office of a practitioner specializing in the vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. 09/05/12

An appointment has been scheduled for resident # 170 for an eye examination for 09-05-2012
Attending physicians will be notified of any resident identified with vision problems through such means as the RAI process, attending physician examination, nursing assessment and/or resident request for an order for eye examination by a qualified professional. Social Services will maintain the referral list and arrange for the examinations by the facility's Ophthalmology Consultant or if desired by the residents private eye physician.

Social Services will report to the Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Activities, Maintenance, and the Medical Director) monthly those residents identified with a need for intervention to promote and maintain vision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 313 Continued From page 17

the resident had glasses from the drug store, could not see out of the left eye, the resident's eye sight was getting worse and the resident needed an eye examination

Interview on August 2, 2012, at 12:55 p.m., with the Director of Nursing (DON), in the DON's office confirmed the resident had not had an eye examination since June 24, 2011.

F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by.
Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place for one (#25) of two sampled residents of forty residents reviewed in Stage Two

The findings included

Resident #25 was admitted to the facility on March 1, 2011, with diagnoses including Hypertension, Diabetes, and Emphysema.

Medical record review of the fall risk assessment dated May 7, 2012, revealed the resident was at high risk for falls

F 313 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F 323

F323 8/31/12
It is the practice of this facility to provide and maintain a safe environment free from hazards over which the center has control and provides appropriate supervision to each resident to prevent avoidable accidents.

1) Resident #25's wheelchair/posture cushion and dycem was evaluated and concluded that dycem was in fact in place in the wheelchair under the posture cushion. The C.N.A. assignment sheets were validated to contain the appropriate care plan information, including safety devices.

2) The Interdisciplinary Care Plan Team will review residents with a fall in the past 30 days to ensure all plans of care developed for falls are current & accurate and all safety devices are in place as indicated by the care plan and are on the C.N.A. assignment sheet and have been communicated to nursing staff.

3) The DNS/ADNS/SDCC and/or designees will in-service all nursing personnel on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 323 Continued From page 18

Review of the facility investigation dated April 4, 2012, revealed "(first fall) ..CNA (certified nursing assistant) saw resident sitting in middle of floor in front of w/c (wheelchair) ..Resident states " I slid out of chair " No injuries. .Intervention dycem to w/c .."

Review of the facility investigation dated April 4, 2012, revealed "(second fall). .While resident was reaching for tray slid out of chair hit (right) eye.. ice to (right) eye. .Intervention: dycem placed in chair to keep cushion (and) resident from sliding...w/c had been power washed dycem removed for cleaning . "

Observation on August 2, 2012, at 8:40 a.m., with Occupational Therapist #1, revealed the resident transferring from the commode to the w/c in the bathroom Further observation revealed a wedge cushion and dycem in the w/c.

Interview on August 2, 2012, at 9:00 a.m , with the Director of Nursing, in the conference room, confirmed the dycem was not in place at the time of the second fall on April 4, 2012.

F 328 SS=D 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care,
Tracheal suctioning;
Respiratory care,

F 323 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

August 23,24,28,29 and 30, on ensuring safety devices are in place as ordered. The Unit Managers will maintain a current list of residents with safety devices on their respective units. The Unit Managers will conduct audits /rounds at least 3-5 days a week to validate care planned safety devices are in place and in use.

4) The DNS/ADNS/SDC or designee will report results of the audits to the Facility Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Maintenance, Activities, and Medical Director) monthly for review to ensure residents receive adequate supervision and assistive devices to prevent falls with serious injury.

F 328

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 19 Foot care, and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure oxygen was in use for one (#53) two sampled residents of forty residents reviewed in Stage Two. The findings included: Resident #53 was admitted to the facility on March 11, 2009, and readmitted on October 27, 2011, with diagnoses of Congestive Heart Failure, Emphysema, and Chronic Obstructive Pulmonary Disease Medical record review of the quarterly Minimum Data Set (MDS) dated July 11, 2012, revealed the resident was cognitively intact, totally dependent for all activities of daily living (ADL'S), and oxygen was used. Medical record review of the Care Plan dated July 20, 2012, revealed "...oxygen at 2 lpm (liters per minute) via (by way of) NC (nasal cannula).. O2 (oxygen) Sat (saturation) above 90% (percent) " Medical record review of the physician's recapitulation orders dated August 1, 2012, through August 10, 2012, revealed "...Oxygen at 2L/Min via NC for SOB (shortness of breath). " Observation on August 1, 2012, at 4:30 p.m., in the front lobby, revealed the resident sitting in the wheelchair, oxygen tank and a nasal cannula	F 328	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F328 It is the practice of this facility to ensure that residents receive proper treatment and care for special services for respiratory care. Resident #53 has oxygen at 2 liter per minute by way of nasal cannula and may remove to her tolerance while visiting in the lobby or dining room per physician order. Resident and family (son) have been educated on oxygen use when (resident) [is] out of her room. Son validated understanding by return demonstration and his signature on August 2, 2012. The DNS/ADNS/Unit managers have reviewed all residents on oxygen therapy and/or with physician orders for oxygen i.e. PRN for appropriate orders, timelines for use i.e. PRN, while awake , while asleep, continuous,)2 saturation measurements and frequency of, etc. as well as for ordered allowed "free time". Care Plans reviewed and updated as needed. The Unit Manger educated LPN # 2 on the policy and procedure for following physicians order for administration of oxygen. The Staff Development Coordinator will include information on the policy and procedure for oxygen administration in the orientation of new licensed staff.	09/10/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 328 Continued From page 20

attached to the back of the wheelchair, and the oxygen was not in use.

Interview with Licensed Practical Nurse (LPN) #2 on August 1, 2012, at 4:35p m., in the front lobby, revealed the resident's oxygen saturation level was 89%, the oxygen had not been in use, and the facility failed to provide oxygen to maintain oxygen saturation level above 90%.

C/O #29469

F 441 SS=E 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility,
(2) Decides what procedures, such as isolation, should be applied to an individual resident, and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if

F 328

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F 441

The Unit Managers will maintain a list of residents oxygen orders at each nurses station and during routine rounds monitor to ensure in use as ordered. Unit manager will conduct audit rounds at least 2-3X a week for 4 weeks, then weekly X 2 months to ensure on-going compliance.
The Director of Nursing, or her designee, will validate on weekday morning clinical rounds that the Treatment Record reflects appropriate documentation for oxygen use and oxygen saturation percentage on those residents with an order for oxygen.

The Director of Nursing (DNS) will report to the Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Activities, Maintenance, and the Medical Director) the audit findings to include any resident non-compliance at its monthly meeting for review, discussion and recommendations, if indicated .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 441 Continued From page 21

direct contact will transmit the disease
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, facility policy review, and interview the facility failed to follow isolation precautions for one (#232) resident reviewed in Stage Two, and failed to follow handwashing and infection control practices on two of six halls

The findings included

Observation on July 31, 2012, at 9.15 a.m., revealed a box of isolation masks located on the railing outside of resident #232's room. Continued observation revealed no signage or other items outside of the resident's room

Medical record review of a Physician telephone order dated July 28, 2012, revealed "...Bactrim per tube for MRSA (methicillin resistant staphylococcus aureus) start July 28, 2012 end August 6, 2012 "

Review of the facility policy for Transmission Based Precautions revealed, "...Place and

F 441

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F441 09/10/12

It is the practice of this facility to provide and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment that prevents the development and transmission of disease or infection

The Staff Development Coordinator in-serviced C.N.A. #3 on proper hand washing between doffing and donning of gloves when providing direct care to residents on 7/31/12
LPN # 1 has been educated on proper hand washing procedure when obtaining blood samples on 07/31/12.
LPN # 3 has been educated on proper Cleaning and Disinfecting Diagnostic Equipment In-Between Patients, i.e., blood glucose testing equipment. Education also included equipment to be and not to be taken into resident's room, i.e., the blood glucose strip container.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 22	F 441	*This Plan of Correction is the center's credible allegation of compliance.*	

maintain an adequate supply of appropriate personnel equipment by the isolation room at the door or use an over the door storage system. "

Interview with the 300 hall Nurse Manager on July 31, 2012, at 10.28 a.m . outside the resident room confirmed there was no signage to indicate isolation precautions and the facility policy for Transmission Based Precautions was not followed

Observation on July 31, 2012, at 9:43 a.m., on the 300-hundred hall revealed Certified Nurse Aide (CNA) #3 checking resident's bed alarms in the resident's rooms. Further observation at this time revealed CNA #3 entered a resident's room touching the resident's personal items, exited the resident's room, entered another resident's room touching personal items, exited the resident's room, entered another resident's room and obtained vital signs without washing the hands or using hand sanitizer

Review of the facility policy Hand Hygiene/Hand washing dated August 31, 2011, revealed " .hand washing is the single most important procedure for preventing the spread of infection.. hand hygiene is to be performed: between patient contacts..."

Interview with CNA #3 on July 31, 2012, at 9:45 a.m., in the 300 hallway, confirmed hand washing or hand sanitizing had not been performed between contacts with the residents.

Observation on August 1, 2012, at 12:00 p.m., on the 300 hundred hallway, revealed Licensed Practical Nurse (LPN) #3 entered the resident's

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

C.N.As will be in-services on proper hand washing between doffing and donning of gloves when providing direct care to residents personnel on August 23,24,28,29 and 30. Licensed Nursing personnel will be in-serviced on Cleaning and Disinfecting Diagnostic Equipment In-Between Patients, i.e., blood glucose testing equipment, Hand Hygiene/Hand Washing procedures when obtaining blood samples to ensure that the spread of infection is prevented on August 23,24,28,29 and 30 . All nursing staff will be educated on August 23,24,28,29 and 30, 2012 on the facility's Transmission Based Precaution requirement to include appropriate signage to be posted at the door of any resident who is placed on transmission based precautions.
The Director of Nursing Services (DNS) or designee will conduct all in-services

The DNS/ADNS/Unit Managers or designee, will conduct audits, through observations at least 3-5 days a week

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 441 Continued From page 23

room with a bottle of blood glucose strips, applied gloves, obtained a drop of blood on a blood glucose strip, exited the resident's room with the gloves in place carrying the bottle of blood glucose strips, and the blood glucose strip to the medication cart in the hall. Further observation at this time revealed the bottle of blood glucose strips were placed in the glucometer case and the glucometer case had visible dried blood on the lid.

Review of facility policy, Cleaning and Disinfecting Diagnostic Equipment In-Between Patients, dated October 31, 2010, revealed "...equipment such as glucometer...are cleaned in-between patient use to prevent the spread of infection ..clean the outside of patient equipment...when visibly soiled..."

Interview with LPN #3 on August 1, 2012, at 12.10 p.m., in the 300 hallway, confirmed the blood glucose strip contaminated with blood was carried out into the hallway, the blood glucose bottle was carried with the contaminated gloves from the resident's room placed in the glucometer case, and dried blood was on the lid of the glucometer case.

Observation on July 31, 2012 at 4:00 p.m. with LPN #5 revealed the following: LPN #5 pushed the medication cart down the hall with gloves on, continued to look through the medication records on top of the medication cart with the same gloves on; entered the resident's room with the blood glucose strip and lancet with the same gloves on; stuck the resident's finger and obtained a drop of blood on the blood glucose strip without washing the hands and applying

F 441

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

monitor licensed and non-licensed staff for proper hand hygiene when performing resident care procedures X 4 weeks and then at least monthly thereafter, to assure nursing personnel are performing proper hand washing techniques when providing resident care.
The DNS/ADNS or her designee will provide individualized counseling and/or disciplinary and additional training immediately to nursing staff members with deficient practice identified through this process.
The DNS/ADNS or designee, will report to the Quality Assurance Committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Maintenance, Activities, and Medical Director) findings of observations, status of education/return demonstrations to determine any additional action if indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 24 clean gloves, removed the gloves in the resident's room and carried the blood glucose strip with blood out to the medication cart in the hall. Interview on July 31, 2012, at 4:00 p m , with LPN #5, in the hall, confirmed LPN #5 did not wash the hands and apply clean gloves prior to obtaining the blood glucose and confirmed the blood glucose strip contaminated with blood out was carried out into the hall.	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by. Based on medical record review and interview, the facility failed to obtain a laboratory test for one (#106) ten sampled residents of forty residents reviewed in Stage Two The findings included: Resident #106 was admitted to the facility on July 6, 2011, with diagnoses including Hypertension, Congestive Heart Failure, and Diabetes. Medical record review of the physician's orders dated July 1, 2012, through August 10, 2012, revealed "...CBC (with) Diff (complete blood count with differential) Q (every) 6 mo (months) Jul (July)/Jan (January). " Interview on August 2, 2012, at 10:50 a.m with	F 502	The DNS/ADNS will present the results of the lab work audits to the Quality Assurance Committee (Administrator, DNS, ADNS,SDC, RD, Social Services, Maintenance, Activities, and Medical Director) monthly for review and action, as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDON HEALTH CARE CENTER	1520 GROVE ST BOX 190 LOUDON, TN 37774

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 25 LPN #4, at the nursing station, confirmed the CBC was not done in July as ordered.	F 502	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F502 It is the practice of this facility to ensure that the residents receive the care and physician ordered laboratory tests are completed as ordered. Resident #106-.Lab work has been completed as ordered and reported to the attending physician on 8/2/2012. An audit of laboratory orders for all residents was completed on 8-06-2012 and all laboratory tests have been completed and reported as ordered or scheduled as per physician orders. The licensed nursing staff has been in-serviced on 8-06-2012 on obtaining orders for, implementing collection of labs, ensuring that the physician is notified of the results and the results are secured in the residents medical record. The 7 p.m. – 7 a.m. shift will review all new physician orders and record ordered lab work on the "new orders review sheet" and on lab schedule log. The DNS/ADNS will review the new order sheets & lab logs during weekdays clinical rounds to ensure that all lab work ordered has been completed as ordered.	09/10/12